TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CONSULTANTS IN PAIN MEDICINE PA

MFDR Tracking Number
M4-17-2362-01

MFDR Date Received
April 6, 2017

Respondent Name
LIBERTY MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In review of your explanation of benefits, it seems that code 99144 not supported. Please find enclosed office notes for review of claim. Note addendum made."

Amount in Dispute: $55.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denied as Documentation does not support time increments... Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation. The time the sedation medication was administered was not provided."

Response Submitted by: Liberty Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
July 11, 2016	99144	$55.47	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
3. 28 Texas Administrative Code §134.1 sets out the medical reimbursement guidelines.
4. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W3 – The charge for this procedure exceeds the fee schedule
   - 193 – The charge for this procedure exceeds the fee schedule allowance
   - X031 – This procedure requires a report. Payment for this charge will be recommended upon receipt of the report

Issues

1. What are the denial reasons raised by the insurance carrier during the medical bill review process?

2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99144 rendered on July 11, 2016. The insurance carrier denied the disputed charge with denial/reduction codes; "X031 – This procedure requires a report. Payment for this charge will be recommended upon receipt of the report" and "193 & W3 – The charge for this procedure exceeds the fee schedule allowance."

   28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules ."

   CPT Code 99144 is defined by the AMA CPT Code Book as "Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time."

   Review of the submitted documentation supports that the requestor rendered moderate sedation services, as result, the insurance carrier's denial reasons are not support. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement in the amount of $55.47 for CPT Code 99144. Per Medicare fee schedule, CPT Code 99144 does not have an assigned relative value; as a result, 28 Texas Administrative Code §134.203(f) applies.

   28 Texas Administrative Code §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   28 Texas Administrative Code §133.307(c) (2) (G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable."

   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that reimbursement of $55.47 was due.
   - The requestor does not discuss or explain how reimbursement of $55.47 is a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for reimbursement is therefore not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment in the amount of $55.47 would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment cannot be recommended for CPT Code 99144 rendered on July 11, 2016.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 4, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.